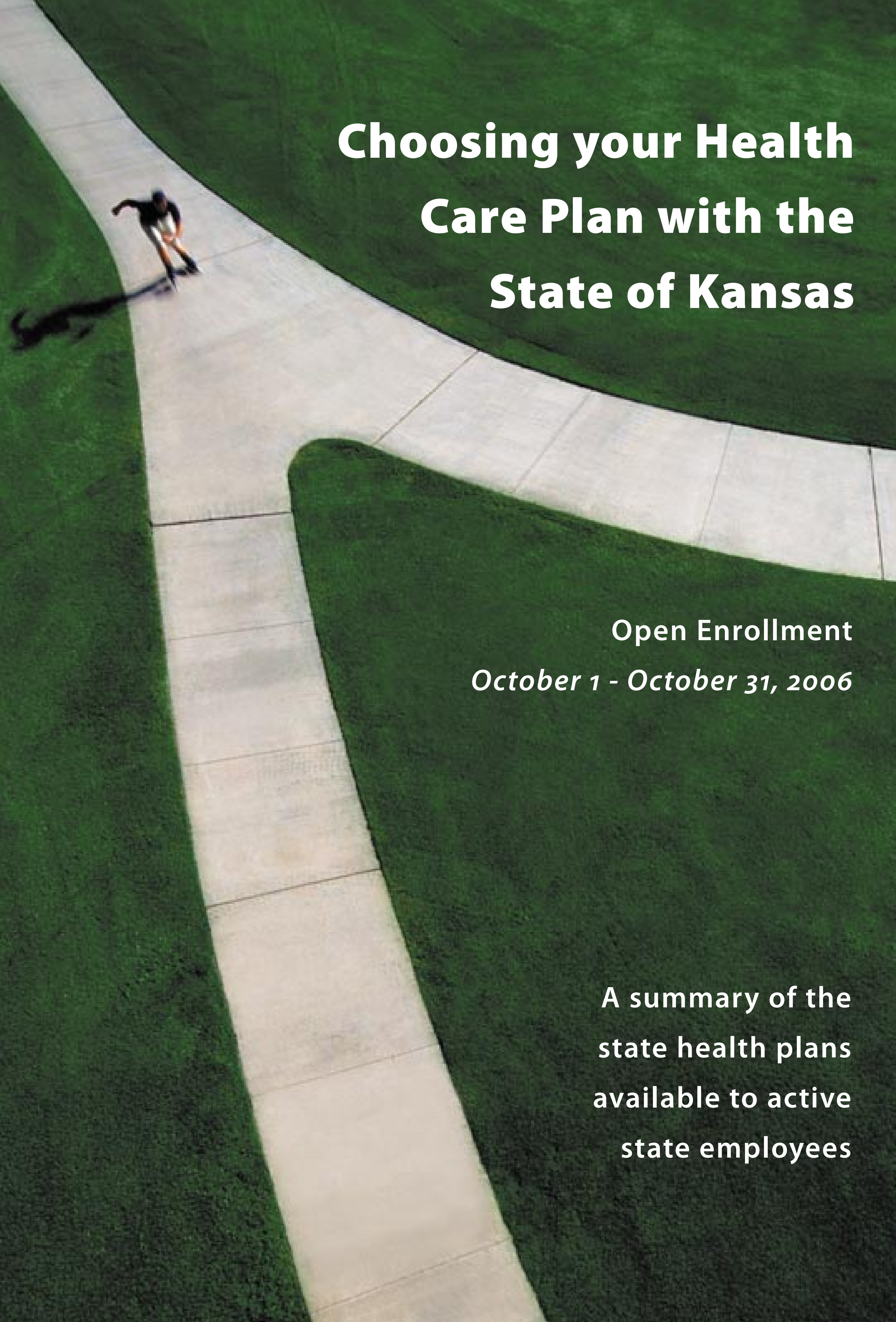

Choosing your Health Care Plan with the State of Kansas

Open Enrollment

October 1 - October 31, 2006

A summary of the state health plans available to active state employees

2007 Health Plan Summary

Providers

Health plan providers web site

http://www.khpa.ks.gov

Blue Cross Blue Shield	
Kansas Choice (PPO)	*Outside Topeka* 800.332.0307 *In Topeka* 785.291.4185
Premier Blue (HMO)	*Outside Topeka* 800.332.0028 *In Topeka* 785.291.4010
Health Management Strategies	*Toll free* 800.952.5906 *In Topeka* 785.233.1165
Coventry Health Care of Kansas	
Coventry PPO, HMO & QHDHP - HSA	*Kansas City/Topeka area* 800.969.3343 *Wichita/South central area* 866.320.0697
United Behavioral Health Services	866.607.5970
FirstHelp (24 hr nurse line)	800.622.9528
Preferred Health Systems	
Preferred Plus of Kansas (HMO)	*Outside Wichita* 866.618.1691 *In Wichita* 316.609.2555
Behavioral Health Systems	*Outside Wichita* 866.338.4281 *In Wichita* 316.609.2541
LabOne	
Lab Card Program	*All areas* 800.646.7788
Collection sites web site	http://www.labcard.com
Delta Dental of Kansas, Inc.	
Dental Plan	*Outside Wichita* 800.234.3375 *In Wichita* 316.264. 4511
Caremark	
Prescription Drug Plan	*All areas* 800.294.6324 *TDD* 800.863.5488
Superior Vision Services	
Vision Plan (optional)	*All areas* 800.507.3800
ASI	
KanElect-Flexible Spending Accounts	*All areas* 800-366-4827 *Toll free fax* 866-381-9682

Forward

Forward

This booklet is a summary of information about state health plans available to members. It is intended to provide basic information about these plans. This summary is also available online at http://www.khpa.ks.gov.

A complete list of all policies concerning member health plans is available in the Employee Benefit Guidebook, located on the state of Kansas web site located at http://www.khpa.ks.gov.

Open Enrollment is between October 1 and October 31, 2006. Changes go into effect January 1, 2007.

This booklet is intended to be of use for members who are enrolling in a state health plan for the first time and for those who wish to make changes in their existing health plan. The time to join or make changes in health plans is during open enrollment, between October 1 and October 31, 2006. Any changes initiated during this period go into effect January 1, 2007.

For members who do not wish to make any changes in their existing health plan or those who do not wish to participate, no action is needed during Open Enrollment.

Enrollment in KanElect and HealthyKIDS does not roll forward from year to year

However, any member who wishes to enroll or reenroll in KanElect or HealthyKIDS must do so during open enrollment. Enrollment in KanElect or HealthyKIDS does not roll forward from year to year.

This booklet is laid out in broad sections. After this forward, important general information is provided, followed by 2007 changes in health plans and a description of the open enrollment process. Then an overview of your health plan choices is provided.

Types of plans available

The types of health plans available to members include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and a Qualified High Deductible Health Plan (QHDHP) with Health Savings Account (HSA). All of these health plans include a prescription drug plan.

Special care should be taken to identify the network of health care providers provided by each of the health plans. For example, each of the three HMOs available to members provide the exact same medical coverage; the difference between each HMO is in the network of participating providers. The same is also true of the two PPOs available to members; the medical coverage they provide is the same but the network of providers in each is different.

Information is also provided about prescription, dental and vision plans. Also discussed are programs such as HealthyKIDS, KanElect, Lab Card, and K-SHIP, the hearing improvement program.

2007 Changes

2007 benefit changes

Preferred Provider Organization (PPO)

>> One routine age appropriate colonoscopy per person per lifetime covered under preventive care service allowance, then subject to coinsurance. Additional colonoscopies are subject to deductible and coinsurance.

Health Maintenance Organization (HMO)

>> Waive copay and coinsurance for one routine age appropriate colonoscopy per person per lifetime. Additional colonoscopies are subject to copay and co-insurance.

Qualified High Deductible Health Plan (QHDHP/HSA)

>> One routine age appropriate colonoscopy per person per lifetime covered under preventive care service allowance, then subject to coinsurance. Additional colonoscopies are subject to deductible and coinsurance.

>> Employer contribution to the Health Savings Account (HSA) for both single and dependent coverage.

Health Savings Account (HSA)

>> To complete the enrollment process the Health Savings Account Enrollment form, to set up your bank account with UMB, must be received by December 31, 2006, or you will be reverted to the health plan you were enrolled in during plan year 2006. If you were not enrolled in a health plan during plan year 2006 your health plan coverage will be waived for Plan Year 2007.

>> For members who enroll in the QHDHP for plan year 2007 and who were enrolled in the KHCFSA in plan year 2006 *will not be eligible* to contribute to the HSA until March 1, 2007.

Dental

>> Coverage provided for composite (white) resin restorations for posterior (back) teeth.

>> Implants are covered at the maximum allowance for a three-unit bridge. The member is responsible for the difference in cost between a three unit bridge and an implant.

KanElect - Health Care Flexible Spending Account (HCFSA)

>> For plan year 2007, the Health Care FSA will not offer a grace period for incurring claims after December 31, 2007.

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Text figures

Employer Contribution

figure 1: Employer's financial contribution to your health plan

	HealthyKIDS HMO area	HealthyKIDS PPO area	Dental Plan	QHDHP counties	QHDHP – HSA contribution	PPO counties	HMO counties
Full-Time 1 - less than $27,000							
Employee Only	n/a	n/a	13.19	97.69	37.50	153.69	136.25
Employee & Spouse	n/a	n/a	19.13	144.55	56.25	229.11	203.17
Employee & Child(ren)	236.65	266.97	17.94	135.58	56.25	214.42	190.18
Employee & Family	306.56	345.39	23.88	185.43	56.25	292.84	260.10
Full-Time 2 - $27,000 to $47,000							
Employee Only	n/a	n/a	13.19	97.69	37.50	149.83	132.83
Employee & Spouse	n/a	n/a	19.13	144.55	56.25	221.38	196.33
Employee & Child(ren)	236.65	266.97	17.94	135.58	56.25	207.47	184.03
Employee & Family	306.56	345.39	23.88	185.43	56.25	282.02	250.53
Full-Time 3 - more than $47,000							
Employee Only	n/a	n/a	13.19	97.69	37.50	145.97	129.42
Employee & Spouse	n/a	n/a	19.13	144.55	56.25	213.65	189.50
Employee & Child(ren)	236.65	266.97	17.94	135.58	56.25	200.52	177.88
Employee & Family	306.56	345.39	23.88	185.43	56.25	271.20	240.97
All Part Time							
Employee Only	n/a	n/a	13.19	77.76	28.13	118.92	105.50
Employee & Spouse	n/a	n/a	19.13	115.27	42.19	175.98	156.19
Employee & Child(ren)	n/a	n/a	17.94	108.17	42.19	164.97	146.45
Employee & Family	n/a	n/a	23.88	148.68	42.19	225.03	200.14
HealthyKIDS							
Employee & Child(ren)	236.65	266.97	17.94	171.46	37.50	n/a	n/a
Employee & Family	306.56	345.39	23.88	221.31	56.25	n/a	n/a

* All columns represents semi-monthly payments. The Health Savings Account (HSA) contributions for 9 month regents employees are made over 16 pay periods per year: each contribution is larger than those for the 24 payment schedule, but the total yearly state contribution is the same. See page 23 for more HSA details.

Important general Information

Preexisting medical conditions

>> The State of Kansas does not apply a waiting period for coverage of preexisting medical conditions.

Medical insurance plan eligibility

>> Medical insurance plan eligibility is determined by county of residence, including the county of residence for members who live in another state. As members go on-line to join or make changes to their health plan, the Open Enrollment screen will display only those plans available in the member's county of residence. For HMOs, the member and all covered dependents must reside within the designated enrollment area.

Prescription Drug

>> Prescription drug coverage is provided for members enrolled in a health plan. The cost of the prescription drug plan is included in the health plan rates.

Dental coverage

>> Single dental coverage is provided for all members enrolled in medical coverage. Members may choose to add dependent dental coverage. Dependents enrolled in the dental plan must match those enrolled in the medical plan.

Vision plan

>> Those enrolled in the vision plan in 2006 will be enrolled in 2007 unless a change is made during open enrollment. Members may choose basic or enhanced vision coverage regardless of whether they are enrolled in a health or dental plan. If dependent children are enrolled in both health and vision coverage, the same dependents must be enrolled in both.

State's financial contribution to your health plan (see left, figure 1)

>> For full time members, the state continues to pay about 95 percent of health care coverage for single only and 45 percent for dependent coverage. Under the HealthyKIDS program, the state pays 90 percent of the health care premiums for children if the member and their children are enrolled in one of the state health plans and the family would be eligible for the HealthWave program but cannot access that program because under federal law it is unavailable to members (See HealthyKIDS program, page 9)

>> The state contribution to member health care premiums is based on the lowest cost HMO in the member's county of residence, unless the member lives in a county where no HMO is available. In that case, the state contribution is based on the lowest cost PPO. In transitional counties, you may choose either the HMO or PPO and the state contribution is based on the low cost option of either the HMO or PPO selected.

>> In any county, if the plan you select is not the lowest cost option, you will pay the difference -- what is called the 'buy-up' -- to the plan of your choice.

Rate comparison charts

>> Rate comparison charts are located on *Rates and Plans Foldout*. The rates listed for each health plan include the cost for medical and prescription drug coverage only. The rates for the Qualified High Deductible Health Plan are listed in the *Rates and Plans Foldout*; contribution amounts for the HSA are on page 23.

Open enrollment

Open enrollment period

The Open Enrollment period between October 1 to October 31, 2006 is your opportunity to join, verify, or make changes to your health plan. Whether you are enrolling for the first time, changing to a different plan or coverage level, waiving your health and dental coverage, or making a Flexible Spending Account or HealthyKIDS election, you must complete the online enrollment process.

Qualifying event

The exception to the ability to make changes only during this open enrollment time period is if you experience what is called a *qualifying event*, which involve major life changing events such as the birth or adoption of a child, marriage, divorce or death of a spouse or dependent. (For more information on qualifying events, see page 8)

Employees joining health care plans for first time or making changes in existing plans

New employees have to be entered in SHARP by September 1 to be able to enroll online. Employees not entered by this date must contact their human resource office to fill out an enrollment form.

Members joining a health plan for the first time or members who want to make changes in their existing plans, can do so during October by going online through the Employee Self Service Center. Before doing that, members should be aware of all their options. Here is a suggested checklist:

>> Read all the Open Enrollment materials.

>> Attend an Open Enrollment meeting. It may be helpful to hear explanations and ask questions. Contact your agency human resource office for the dates and times of meetings near you.

Are you considering switching health plans?

>> If you are considering switching health plans, check to make sure the health care provider you want to see participates in the plan of your choice. If a change in health plans means you need to choose a new health care provider, call to make sure the new health care provider is accepting new patients.

Adding dependents?

>> For members adding dependents, submit documentation such as a birth certificate or marriage license to your agency human resource office.

Benefit options?

>> For questions about benefit options, contact your agency human resource office or send an email to: benefits@da.state.ks.us or http://www.khpa.ks.gov

Effective date of changes

Changes made in health plans become effective January 1, 2007 and will be reflected on your first paycheck in January 2007. Member contributions for health plans, KanElect FSA's, and the Health Savings Account, are deducted from member's paychecks on a semi-monthly basis or 24 times a year. The only exception to this is for certain Kansas Board of Regents members, who have deductions taken 16 times per year.

If you make health plan changes during open enrollment or are joining a plan for the first time, you will receive a new identification card, mailed to your home address in December.

When does coverage begin?

State health plan coverage is monthly. New enrollment or changes in enrollment or coverage during the plan year generally begin on the first day of the month following the changes. Termination of coverage or ineligibility for coverage is effective on the last day of the month.

How to enroll

Use any computer with internet access when and where it is convenient such as work, home, a Job Service Center, or at many public libraries. First go to the Employee Self Service Center web site at http://www.kansas.gov/employee/. Then select "Employee Self Service Center", then "Login." From there, follow the instructions on the screen. When you are finished, be sure to submit and save the online open enrollment form.

Help Desk

For first-time users or for members who need help accessing this web site, call the Help Desk at 785-296-1900 (Topeka) or toll-free at 866-999-3001. The Help Desk, which is open 24 hours a day, can provide instructions on how to log in and create a password. Once you have logged in, update your profile by including your email address and set up a secret question and answer. The secret question is used to help members who forget their password.

Required information for dependents of state employees covered by health plans

>> Documentation of the dependent's relationship (such as child, spouse, stepchild, etc.);

- Full name;
- Social Security Number;
- Gender;
- Birth date;
- Primary Care Physician (PCP) number for initial enrollment only on all HMO options. The PCP designation must be made through online enrollment only when selecting a new HMO option. To change your PCP selection without changing carriers, call the HMO.

Who can be covered?

>> A member's wife or husband. (When a member is divorced, coverage of the spouse and stepchildren stops.)

>> A member's unmarried child or stepchild. To be covered under the member's health plan, the child or stepchild must be less than 23 years of age, must not file a joint tax return form with another taxpayer, and must receive more than half their support from the member. The child or stepchild must be a United States citizen, a United States national, or a resident of the United States, Canada, or Mexico at some time during the tax year, and either reside with the covered member for more than six months of the year or not reside with the child's brother, sister, grandparent, aunt or uncle for more than six months of the year.

For a more complete listing of those qualified to be covered under a member's health plan as a dependent, see the Employee Benefits Guidebook.

Qualifying events

The Open Enrollment period allows a member to make any changes to his or her health insurance coverage. However, federal tax law limits those changes mid-year. A member must experience a "qualifying event" to change his or her deduction mid-year. Qualifying events include life-altering events such as birth or adoption of a child, marriage, divorce, death of a spouse or a dependent, gain or loss of employment and benefits for a spouse or a dependent. For a complete list of qualifying events, refer to the online Employee Benefits Guidebook.

Changes in health care coverage must be made within 31 days of a qualifying event

Health plan changes due to a qualifying event must be consistent with the event. Members need to complete a change form within 31 days of the event.

Your enrollment change in the health plan would be effective the first of the month following your qualifying event. If the event takes place on the first day of the month, the effective date is that day.

Remember to contact your agency's human resource office within 31 days of the qualifying event to insure the change you want is implemented.

Employee Advisory Committee

This 21-member committee consists of active state employees and state retirees who advise the Kansas Health Care Commission (HCC) on health care coverage. This committee provides a vehicle for health plan members to express ideas and concerns about the Kansas State Employees Health Plan to the HCC and its staff.

Each member of the Employee Advisory Committee (EAC) serves a three year term. If you are interested in being involved and giving input to the HCC by joining the EAC, please write the Health Benefits Office, Attention EAC, 900 SW Jackson, Room 900-N, Topeka, Kansas 66612, by November of each year. Please feel free to contact any EAC member to provide ideas and suggestions for improvement to the health plans. For current committee members and more information, see http://khpa.ks.gov.

HealthyKIDS program

Services covered

The HealthyKIDS program helps eligible state employees with their premiums for children's health insurance coverage. Eligible families have up to 90 percent of their premium for their covered children paid by the state. Employees are responsible for the remaining 10 percent. Covered services in HealthyKIDS are the same as covered services in the health plan chosen and are subject to copays and coinsurance, if applicable.

Eligibility for HealthyKIDS is based on family income. Children in households with incomes up to 200 percent of the Federal Poverty Level who would otherwise qualify for the federal/state HealthWave program are eligible. See the chart listing 200 percent of the Federal Poverty Level by family size below.

Where and when to submit your application

If you believe you are eligible for HealthyKIDS, print and fill out an application from http://khpa.ks.gov, sign the application, then submit the application and requested supporting material to HealthyKIDS, Landon State Office Building, 900 SW Jackson, Room 900-N, Topeka, KS 66612-1251 ***no later than October 31, 2006.***

Members must reenroll each year for the HealthyKIDS Program.

The application will be processed and results will be provided both to the member and the State Employee Health Plan. If certified, the member's premium for dependent children will be adjusted based on the HealthyKIDS rates.

figure 2: HealthyKIDS 2006 qualifying income maximums

Number of Persons per household	2	3	4	5	6	7
Maximum monthly gross income	2,200	2,767	3,334	3,900	4,467	5,034
Maximum annual gross income	26,400	33,204	40,008	46,800	53,604	60,408

Choosing your health insurance plan

HMO? PPO? QHDHP?

It is the treating physician (and the member), not the health care plan or the employer, who determines the course of medical treatment. Whether or not the plan will cover all or part of the treatment cost is secondary to the decision of what the treatment should be.

Choosing the appropriate health care plan may be easier than you think. The state offers three types of plans:

1. Health Maintenance Organizations (HMO),
2. Preferred Provider Organizations (PPO), and
3. Qualified High Deductible Health Plan with Health Savings Account (QHDHP/HSA).

Each plan has its unique features that allow you to choose the one that meets your needs.

It is important to refer to the *Rates and Plans Foldout* to see which plans are specifically available in your county because not all counties have HMO plans available. The *Foldout* also compares HMO, PPO, and QHDHP coverage. Some time spent reviewing the *Foldout* will help you understand the coverage available and the differences between health plans.

To understand the *Rates and Plans Foldout*, it will help to be familiar with several terms – deductible, copay, coinsurance, coinsurance maximum, network, and non network. The glossary is on page 43.

The prescription drug, dental and vision plans offered are the same for all HMOs and PPOs. The QHDHP prescription drug plan is a different plan than offered with other health plans and has a different Preferred Drug List (PDL).

HMO's

All services require prior approval

HMO's are centered around the important concept of a Primary Care Physician (PCP). In an HMO plan, all services require prior approval or referral from the member's PCP, except as otherwise noted. Your PCP will help you make decisions regarding your health care and then refer you to the next stage of treatment, if needed.

Your PCP and insurance company's network of providers

Your PCP must be a member of your health plan's network of providers. You can contact your existing physician to see if they are on a health plan's network of providers, or you can contact the health plan directly for a list. Provider lists are online at each health plan's web site.

Changing your PCP

You can change your PCP during the year, but any scheduled referral will need to be rescheduled with your new PCP. Changes in PCP selection can only be made by calling the health plan. Changes will become effective the first of the month following notification to the HMO plan.

Financial responsibility for treatment outside network

In an HMO, if you don't use your PCP, or you seek treatment outside of your network, you will very likely be responsible for 100% of the bill you incur. The *Rates and Plans Foldout* allows you to compare the various health plans and their network and non network coverage.

Whatever HMO plan a member belongs to, the coverage is the same. The differences between the plans are the network of providers, and the special features each company offers. See the specific HMO plan pages starting on page 16 or go to health plan web sites to learn more.

Other considerations regarding HMO's:

Reporting emergency room visits

>> All emergency room visits for emergency medical conditions must be reported to the HMO plan within a specified period of time, usually 24 to 48 hours. In cases of life or limb threatening emergencies, you should seek help immediately. For non-life or limb threatening situations, you should call your PCP before seeking treatment.

>> Well Woman Exam. Women may visit an OB/GYN physician participating with their HMO plan for an annual well woman exam without a referral from their PCP.

>> Well Man Exam. Men may visit a urologist/proctologist who participates with their HMO plan for an annual well man exam without a referral from their PCP.

>> HMO's have lower coinsurance maximums and no deductibles. The *Rates and Plans Foldout* allows you to compare the various health plans and rates. Prescription drug coverage is included in each health plan's rates.

PPOs

Access to providers

PPOs allow more freedom to go directly to the provider of your choice without having to go to your regular physician first for a referral. There is no Primary Care Physician (PCP) with a PPO plan.

Access to medical services

PPOs allow broader access to medical services nationally as well. If, for instance, you have a student dependent on your insurance plan and they live out of state, your dependent can seek routine medical services while still in network. With an HMO, only emergency care and other limited services are paid for out of state.

Differences in PPO plans

All Kansas counties have PPO plans. Refer to the *Rates and Plans Foldout* for plan comparisons. Note the existence of both network and non network coverage. Understand that both PPO plans in the state have the same coverage. The specific difference in the two PPO plans are the network of providers in each and the independent features that the individual insurance companies may offer such as online and toll free telephone support.

QHDHP-HSA

QHDHP-HSA is a PPO with a savings account feature or HSA. In a QHDHP-HSA, there are both network and non network pricing structures for health coverage. A QHDHP also provides broader nationwide services and there is an allowance for preventive care. Your prescription drug coverage is included in the health plan although the Preferred Drug List (PDL) is slightly different than the other health plans.

A review of the *Rates and Plans Foldout* will give you a direct comparison to the other health plans. A large proportion of the services you access are subject to deductible and coinsurance.

Dependent coverage

When dependent coverage is selected, the entire family deductible must be met prior to claims being paid for any one individual. (Except for preventive care services up to the $450 preventive care service allowance).

Prescription drugs

Prescription drugs are subject to the deductible of the QHDHP; the Coventry ID card will have the Caremark logo on it for purchase of medications at a pharmacy. A QHDHP Preferred Drug List (PDL) will apply, which is different than the other health plans PDL.

Penalty when enrolling in a Part D

Also, the prescription drug plan is not creditable; that is to say, if you are Medicare eligible and enrolled in this plan you will incur a penalty when you enroll in a Part D.

Health Savings Account (HSA) is a required part of the Qualified High Deductible Health Plan (QHDHP) with minimum and maximum allowable contributions. The purpose of the HSA is to allow members to put tax advantaged savings aside for future medical expenses. The savings can be used for premiums, copays, coinsurance, deductibles or any medical expenses that are not covered in your QHDHP.

The HSA is owned by the member, administered by UMB Bank, and can be funded up to the QHDHP deductible. Members between 55 and 65 can make "catch up" contributions. The HSA account is portable and funds rollover from year to year, unlike a Flexible Spending Account (FSA).

To complete the enrollment process the Health Savings Account Enrollment form, to set up your bank account with UMB, must be received by December 31, 2006, or you will be reverted to the health plan you were enrolled in during plan year 2006. If you were not enrolled in a health plan during plan year 2006 your health plan coverage will be waived for Plan Year 2007.

For members who enroll in the QHDHP for plan year 2007 and who were enrolled in the KHCFSA in plan year 2006 ***will not be eligible*** to contribute to the HSA until March 1, 2007. Because regulations regarding the HSA preclude contributions while covered by the HCFSA, no contributions can be made during the grace period by either the employee or the employer.

Which Provider?

The primary difference in the insurance providers is the specific network of health care providers

Once you have chosen a type of coverage, HMO, PPO, or QHDHP, you next have to choose the particular insurance provider of that plan. For instance, there are three different HMO insurance providers available to members and all provide the same coverage. The primary difference is the specific network of health care providers within each plan. The same is true of the two PPO insurance products: each has a different network of providers. There is only one QHDHP plan available.

Consideration should be given to the special services an insurance provider may offer its members. For instance some insurance providers may have useful online tools, or have toll free telephone numbers available. Check the individual plan pages later in the booklet for more information. You can also go directly to insurance provider web sites to learn more.

The worksheet on the following page will help you choose the plan that is best for you by allowing you to note your current health providers and what network they participate in. Also, be sure to check the *Rates and Plans Foldout* to determine which plans are available in your area. After reviewing the information you should be able to pick the best health plan for you and your family.

Health insurance worksheet

The purpose of the worksheet on the opposite page is to help you determine which specific health insurance product best suits your needs. Some tips for using the worksheet:

What plans are available in your county?

1. Your first step is to go to the *Rates and Plans Foldout* and find your county of residence, then look at the numbers beside your county name. Each number represents a health plan. Not all counties have all health plans available so it is important to review your plan options. The health plan names and numbers are the same on this worksheet and the *Rates and Plans Foldout*. Check the health plans you wish to compare. Depending on your county of residence, there are possibly three different HMO's, two PPO's, and one QHDHP plan available. Notice that the health plan coverage for each of the three HMO's is the same. This is also true of the two PPO's.

What physicians and facilities do you currently use?

2. The second step is to list the physician(s) or specialists for you and/or your family members. Also, list any hospitals or medical facilities that you prefer. If you are comparing an HMO or PPO to a QHDHP, also list your prescriptions taken. A QHDHP has a different Preferred Drug List (PDL) than the HMO and PPO plans and may affect your decision.

What plan's network best fits your existing physicians and facilities?

3. The last step is to go to the specific web site of each health plan you are considering and see if your physician, the medicines you take, and the facilities you prefer are in the particular network. All provider directories are available at: http://www.khpa.ks.gov

A network is created when a health plan provider, for example your physician, enters into a contract with a health insurance company to provide services to members at a pre-negotiated rate. So what you are trying to determine is which health plan's network best fits your current or potential medical needs.

For instance, if you have plans 4, 5 and 6 available in your county of residence, and most of your physicians are in the network for plan 5, then plan 5 would be your most likely choice.

When you are done, the worksheet should have checks in the boxes under the plans you are considering. There should be a list of physicians, specialists and possibly prescriptions in the spaces provided, and a check mark in the column of the health plan/network they participate in. Looking at the check marks, it should be obvious which health plan is likely best for you. Don't forget some health plans still pay benefits for non network services provided, but your out of pocket cost is greater than when a network provider is used. Your goal is to find the best balance for you and your family.

Health insurance worksheet

Health insurance worksheet

List below the names of physicians you want to see and prescriptions you currently use and check red boxes for plans in which they are available: if your list exceeds in number the spaces provided in this column, please copy this page and continue

Check black boxes for plans available in your area

	Coventry HMO (1)	Preferred Plus of Kansas, Inc HMO (2)	Premier Blue HMO (3)	Coventry PPO (4)	Kansas Choice PPO (5)	Coventry QHDHP with HSA (6)
	1	2	3	4	5	6
	HMO1	HMO2	HMO3	PPO1	PPO2	QHDHP
	❑	❑	❑	❑	❑	❑
____________________	❑	❑	❑	❑	❑	❑
____________________	❑	❑	❑	❑	❑	❑
____________________	❑	❑	❑	❑	❑	❑
____________________	❑	❑	❑	❑	❑	❑
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____________________	❑	❑	❑	❑	❑	❑
____________________	❑	❑	❑	❑	❑	❑
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Coventry HMO

Coventry HMO is a fully insured Health Maintenance Organization (HMO) available to members and all covered dependents within Coventry's HMO service area.

You can select from more than 2,100 Primary Care Physicians (PCPs) to be your physician. There are more than 6,580 physicians in the overall network. When you want to see a specialist, you can work with your PCP and choose any specialist in the Coventry HMO network.

Offering comprehensive health benefit plans, Coventry also gives you many wellness extras at no additional cost because we feel it is important to have a health plan that actively supports your health and wellness. With Coventry, you're eligible to participate in these additional programs:

My Online Services – A secure, password-protected online tool giving you 24-hour access to your personal health plan information. Check claims status, print an extra ID card, evaluate hospital quality based on procedures, contact Customer Service, and more. My Online Services is also your gateway to the Coventry Wellbeing Self-Care programs.

Wellbeing Self-Care and Wellness

FirstHelp™ – You have around-the-clock telephone access to experienced nurses who can provide guidance on wellness and health-related issues.

FirstHelp Audio Library – Tap in to a variety of pre-recorded health and wellness topics, available 24 hours a day.

Health risk assessment – This web-based assessment will help you discover your current state of wellness, and target areas for improvement.

Wellness Reminders – You can arrange to send yourself email reminders about important preventive care, such as mammography screenings and immunizations.

Members ChoiceSM – Get discounts on complementary health products and services such as vitamins, massage therapy, acupuncture, and fitness facilities.

My ePHIT® services are a web-based suite of comprehensive wellness programs available exclusively through Coventry helping you enhance your health through exercise, nutrition and self-improvement. Components include:

GetPHIT – personalized exercise programs to meet your goals.

EatPHIT – diet and nutrition planning, including customized meal plans.

LivePHIT – life balance issues, including stress management, family communication and community involvement.

FamilyPHIT – geared for the interests of children and teens.

Online personal coaching – available from the My ePHIT staff of 32 coaches specializing in exercise and nutrition.

Kids Health – A rich online resource for all facets of child health. Specialized learning tools include games and video clips to capture the interests of children and teens.

COVENTRY
Health Care of Kansas, Inc.

Kansas City/Topeka Area: 800-969-3343
Coventry Health Care of Kansas
8320 Ward Parkway
Kansas City, MO 64114

Wichita/South Central Area: 866-320-0697
Coventry Health Care of Kansas
8301 East 21st Street North, Suite 300
Wichita, KS 67206

Customer Service Telephone Numbers
United Behavioral Health: 866-607-5970
FirstHelp: (24 hr. nurse line) 800-622-9528

Preferred Plus of Kansas HMO

Preferred Plus of Kansas (PPK) is a fully insured Health Maintenance Organization (HMO). To enroll in coverage with PPK, all members must reside within the PPK enrollment area.

Your Primary Care Physician (PCP) provides or coordinates all of your health care needs. If you need to see a physician other than your PCP, you will need a written referral authorization except for; emergency services, well-woman or well-man exam, annual diabetic retinal eye exam, routine eye exam or prospective parent PCP visit.

PPK has a large network of specialists. Your PCP will send you to one of these providers if your condition calls for special medical care. However, your PCP may not send you to a specialist if he or she can provide your medical care or feels care by a specialist is not necessary. Please talk to your PCP about your medical care and referral needs. Ask your PCP for a copy of the Referral Authorization Form so you know what was authorized.

Important Points to Remember

- You must have a referral authorization from your PCP for all services not performed by him/her, except for those services stated in your certificate. This includes any treatment recommended by your specialist. If you do not have a referral authorization, you will have to pay for these services.
- Behavioral health and substance abuse services are coordinated by Behavioral Health Systems and do not require a referral authorization from your PCP, but must be pre-authorized by PPK.
- If your specialist recommends additional visits or testing, call your PCP to see if the PCP can perform the testing in their office. Additional services will not be covered unless they are provided or referred by your PCP.
- If you are a new PPK member and have an appointment with a specialist, or are getting medical care from someone other than your PCP, call your PCP as soon as possible to coordinate your care.

It is important to establish a relationship with your PCP. He/she may want to see you in the office before sending you to a specialist or calling in a prescription.

- A referral authorization does not guarantee services will be covered. Call member services to verify coverage and make sure you are using contracting providers.
- Non-emergency medical conditions should be treated in your PCP's office or at a contracting urgent care center. PCPs are available 24 hours a day to help you get the care you and your family need. In most cases, non-emergent care is not covered when received in a hospital emergency room. If you have an emergency medical condition such as difficulty breathing or suspected heart attack, and time allows, use a contracting hospital emergency room. If you are able and choose to go to a non-contracting hospital, your care would not be covered.
- Wesley Medical Center and Galichia Heart Hospital are not contracting providers and your out-of-pocket costs could be substantial.
- PPK members can access provider, claims and plan information at www.phsystems.com or contact us at phsimail@phsystems.com

Preferred Plus of Kansas

Mailing Address:
Preferred Plus of Kansas
8535 E. 21st Street North
Wichita, KS 67206

Customer Service Telephone Numbers:
Toll free: 866-618-1691
In Wichita: 316-609-2555

Behavioral Health Systems:
in Wichita 316-609-2541
in all other areas 866-338-4281

Premier Blue HMO

Premier Blue HMO is a program offered by Blue Cross and Blue Shield of Kansas. Premier Blue is a four-way health care partnership – involving hospitals, doctors, Premier Blue and you – working together to achieve good health in a proactive, preventive way.

- You select your Primary Care Physician (PCP) from a wide network of credentialed family physicians, internists and pediatricians.
- Your PCP will supervise and coordinate all your health care needs, providing referrals as appropriate. Choose one PCP for your family, or a different one for each family member.
- You may obtain certain services, such as well-woman services and routine eye exams, from network providers other than your PCP without a referral.
- Office visits are subject to a low copay, and many annual screening services are covered at 100 percent when you use a contracting provider.
- The plan makes preventive care more affordable, with virtually no paperwork, so visits to your doctor are easy.
- Problems can be detected earlier; illnesses treated before they become serious; and plans can be explored to help you achieve a healthier lifestyle.
- You are covered for initial treatment whenever and wherever you travel.

Premier Blue Advantages

Excellent Customer Service – You receive fast, efficient claims processing and the attention of our dedicated customer service staff.

Web Services – Sign up at www.bcbsks.com to view your Summary of Claims Processed online … it's convenient, fast and secure! Other valuable online resources include a list of contracting providers, answers to frequently asked questions, our Resource Blue health and wellness section, and more.

Resource Blue – You're eligible for our free value added program with discounts available on alternative medicine resources such as massage, acupuncture, nutritional counseling, exercise and movement, mind and body therapies and fitness centers. Additional health and wellness tools are also available to you; health risk appraisals, personalized health dashboard, disease and conditions centers. Find more information on our web site at www.bcbsks.com/resourceblue.

Care Management – The nurse care manager assists members who choose to participate with appropriate self-management of diabetes, coronary artery disease, asthma, congestive heart failure and depression. Periodic telephone calls, free educational materials and quarterly health mailings provide information and ongoing support.

Case Management – By referral, a registered nurse case manager works with the member, the member's family, doctor and other members of the treatment team to develop an ongoing plan of care. Examples of conditions that might benefit include head injuries and strokes, severe burns, high-risk pregnancies and premature/high-risk infants.

PremierBlue

BlueCross BlueShield of Kansas

*An Independent Licensee of the Blue Cross and Blue Shield Association
®Registered mark of the Blue Cross and Blue Shield Association

Premier Blue HMO
P.O. Box 3518
Topeka, KS 66601-3518

Customer Service:
Toll free: 800-332-0028
In Topeka: 785-291-4010

Health Management Strategies:
Toll free: 800-952-5906
In Topeka: 785-233-1165

Coventry PPO

Coventry PPO allows you to seek care from any physician, without referral, from the extensive Coventry PPO network of over 7,640 health care providers. With so many providers to choose from, you're sure to find one close to your work or home. With the PPO plan, you can get care from physicians who are not part of the Coventry network, however, you'll enjoy the highest level of benefit from your health plan if you see physicians who are part of the Coventry PPO network.

Offering comprehensive health benefit plans, Coventry also gives you many wellness extras at no additional cost because we feel it is important to have a health plan that actively supports your health and wellness. With Coventry, you're eligible to participate in these additional programs:

My Online Services – A secure, password-protected online tool giving you 24-hour access to your personal health plan information. Check claims status, print an extra ID card, evaluate hospital quality based on procedures, contact Customer Service, and more. My Online Services is also your gateway to the Coventry Wellbeing Self-Care programs.

Wellbeing Self-Care and Wellness
FirstHelp™ – You have around-the-clock telephone access to experienced nurses who can provide guidance on wellness and health-related issues.
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Health risk assessment – This web-based assessment will help you discover your current state of wellness, and target areas for improvement.
Wellness Reminders – You can arrange to send yourself email reminders about important preventive care, such as mammography screenings and immunizations.
Members ChoiceSM – Get discounts on complementary health products and services such as vitamins, massage therapy, acupuncture, and fitness facilities.

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LivePHIT – life balance issues, including stress management, family communication and community involvement.
FamilyPHIT – geared for the interests of children and teens.
Online personal coaching – available from the My ePHIT staff of 32 coaches specializing in exercise and nutrition.
Kids Health – A rich online resource for all facets of child health. Specialized learning tools include games and video clips to capture the interests of children and teens.

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8301 East 21st Street North, Suite 300
Wichita, KS 67206

Customer Service Telephone Numbers
United Behavioral Health: 866-607-5970
FirstHelp: (24 hr. nurse line) 800-622-9528

Kansas Choice PPO

Kansas Choice PPO offers flexibility to see any doctor you choose, including a specialist, without a referral.

- Developed by the State of Kansas for State Employees.
- Coverage is recognized anywhere you go and includes the same services available under comprehensive benefit plans.
- The difference is the PPO provider network – in Kansas and nationwide – created with contracting hospitals, medical professionals, medical equipment suppliers and ambulatory surgical centers.
- To receive maximum network benefits, simply use Kansas Choice network hospitals and providers, and obtain pre-admission certification before planned admissions.
- PPO network providers accept our payment allowance for covered services as payment in full, and automatically file your claims for you.
- With Kansas Choice coverage, your BlueCard® lets you take your health care benefits with you – across the country and around the world.
- More than 85 percent of all doctors and hospitals throughout the U.S. contract with Blue Cross and Blue Shield Plans.
- Worldwide, you have access to doctors and hospitals in more than 200 countries.

Kansas Choice Advantages

Excellent Customer Service – You receive fast, efficient claims processing and the attention of our dedicated customer service staff.

Easy Access – Your Blue Cross ID Card is welcomed across the U.S. and worldwide.

Web Services – Sign up at www.bcbsks.com to view your Summary of Claims Processed online … it's convenient, fast and secure! Other valuable online resources include a list of contracting providers, answers to frequently asked questions, our Resource Blue health and wellness section, and more.

Resource Blue – You're eligible for our free value added program with discounts available on alternative medicine resources such as massage, acupuncture, nutritional counseling, exercise and movement, mind and body therapies and fitness centers. Additional health and wellness tools are also available to you; health risk appraisals, personalized health dashboard, disease and conditions centers. Find more information on our web site at www.bcbsks.com/resourceblue.

Care Management – The nurse care manager assists members who choose to participate with appropriate self-management of diabetes, coronary artery disease, asthma, congestive heart failure and depression. Periodic telephone calls, free educational materials and quarterly health mailings provide information and ongoing support.

Case Management – By referral, a registered nurse case manager works with the member, the member's family, doctor and other members of the treatment team to develop an ongoing plan of care. Examples of conditions that might benefit include head injuries and strokes, severe burns, high-risk pregnancies and premature/high-risk infants.

BlueCross BlueShield of Kansas

*An Independent Licensee of the Blue Cross and Blue Shield Association
®Registered mark of the Blue Cross and Blue Shield Association

Kansas Choice PPO
1133 SW Topeka Blvd.
Topeka, KS 66629-0001

Customer Service:
Toll free: 800-332-0307
In Topeka: 785-291-4185

www.bcbsks.com

LabOne *now a part of Quest Diagnostics*

Lab Card - an added feature of Kansas Choice and Coventry PPO

The Lab Card program is a value added feature of the Kansas Choice and Coventry PPO plans. When you use LabOne, now a part of Quest Diagnostics, for outpatient lab work covered by the medical plan, the cost will be covered at 100% with no copay, no deductible and no coinsurance. Using the Lab Card program is easy as 1-2-3….

1. When your physician orders laboratory work for you, show your Lab Card, Kansas Choice or Coventry PPO cards and tell them that you would like to take advantage of the benefits offered by Lab Card. Instructions for your physician's office are printed on the back of the Lab Card.
2. Your physician's office collects your specimens and calls for courier pick-up *or* your physician will write out the orders for the lab work and send you to a Lab Card contracted collection site.
3. Testing will be performed by LabOne and your physician will receive the results within 24 - 48 hours.

It Is Your Responsibility to inform the physician about your Lab Card eligibility. Present your Lab Card at the time of service. The ID number on the Lab Card tells LabOne how to bill your insurance so payment can be made correctly. The collection sites will need a copy of your Lab Card each time you go for services. The Lab Card covers routine outpatient testing. The Lab Card **does not cover**:

What the Lab Card does not cover

>> Testing ordered during hospitalization
>> Lab work needed on an emergency or (STAT) basis
>> Testing done at any other laboratory
>> Time sensitive esoteric testing such as fertility testing, bone marrow studies and spinal fluid tests

LabOne has added additional couriers in the State of Kansas and generally a physician can arrange for specimen pick-up two times each day.

There are also additional collection sites throughout the State of Kansas. A complete list is available on the web site: www.labcard.com

LabOne is now a part of Quest Diagnostics

Remember, the Lab Card program is completely voluntary. If you and your physician elect to use a lab other than LabOne – including the lab in your physician's office, you still have coverage and regular plan benefits will apply. When your physician orders laboratory work for you, show your Lab Card, Kansas Choice, or Coventry PPO cards and tell them that you would like to use the Lab Card. Instructions for your physician's office are printed on the back of the Lab Card. At your physician's office or contracted collection site, be sure to verbally request to use your Lab Card benefit.

LabOne Inc.

now a part of Quest Diagnostics

Telephone: 1-800-646-7788
www.labcard.com

Coventry QHDHP-HSA

Coventry QHDHP-HSA Combining our Qualified High-Deductible Health Plan (QHDHP) with a Health Savings Account (HSA) enables you to gain added control over your health care costs. Although your monthly premium is lower, you must meet higher deductibles before your plan coverage activates. Setting up a tax-advantaged HSA account with UMB Bank enables you to put money aside to cover the costs of deductibles.

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LivePHIT – life balance issues, including stress management, family communication and community involvement.

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Customer Service Telephone Numbers
United Behavioral Health: 866-607-5970
FirstHelp: (24 hr. nurse line) 800-622-9528

Health Savings Account - HSA

Health Savings Account (HSA) is a required part of the Qualified High Deductible Health Plan (QHDHP) with minimum and maximum allowable contributions. The purpose of the HSA is to allow members to put tax-advantaged savings aside for future medical expenses. The savings can be used for premiums, copays, coinsurance, deductibles or any expenses that are not covered in your QHDHP.

The HSA is owned by the member, and administered by UMB Bank and can be funded up to the QHDHP deductible. Members between 55 and 65 can make "catch up" contributions and the HSA account is portable and funds rollover from year to year, unlike the Flexible Spending Account (FSA).

You are *not* eligible for an HSA if:

>> you are enrolled in Medicare,

>> you are covered by another health plan that is not a QHDHP,

>> you are enrolled in the KanElect Health Care FSA (or covered by a spouse's HCFSA). If enrolled in the 2006 KanElect HCFSA, you must waive out of the "grace period,"

>> you are covered by TRICARE and TRICARE for Life, or

>> you are covered by VA benefits and have used VA medical services within the previous 3 months.

figure 3: Health Savings Account contributions

Full-Time Employee	Employer contribution	Employee contribution	Enter amount of your contribution
Employee Only	37.50	25.00	________
Employee & Dependents*	56.25	25.00 to 68.75	________
Part-Time Employee			
Employee Only	28.13	25.00 to 34.38	________
Employee & Dependents*	42.19	25.00 to 82.81	________

NOTE: All columns represents 24 semi-monthly payments. The Health Savings Account (HSA) contributions for 9 month regents employees are made over 16 pay periods per year: each contribution is larger than those for the 24 payment schedule, but the total yearly state contribution is the same.

*The HSA contribution maximums for Employee and Spouse, Employee & Children, or Employee & Family are the same.

Other plans & programs

Caremark Prescription Drug Plan

Caremark Prescription Drug Plan

Caremark is the Pharmacy Benefit Manager (PBM) administering the self insured prescription drug plan offered to members enrolled in a State of Kansas Health Plan. Caremark has a network of over 65,000 pharmacies nationwide available to plan members.

The coinsurance maximum of $2,580 per member per year applies to your coinsurance for Tier 1 – Generic, Tier 2 - Preferred Brand Name Drugs and the copay for Tier 3 - Special case medications. Once the coinsurance maximum is reached, claims are paid at 100 percent for Tier 1, 2, and 3 drugs for the remainder of that calendar year.

The initial fill of any prescription is limited to a 30-day supply or one standard unit of therapy, whichever is less. Prescriptions can be refilled when 75% of the previous fill has been used. Medications may be refilled for up to a 60-day supply, or two standard units of therapy, if the prescription was written to indicate the larger fill and it is within 120 days of the previous fill for the same medication.

Prescription benefits are included with all health plans and the cost of this program is incorporated into the health plan rates. The Coventry QHDHP has a separate drug policy with different benefits.

The Prescription Drug Plan is a five tier program designed to encourage plan members to partner with their physicians in choosing cost effective medications when needed for the treatment of illness or injury.

The full benefit description, Preferred Drug List and other information related to the Prescription Drug Plan are posted at http://www.khpa.ks.gov

Mail Order Options

For your convenience, Caremark offers a mail order option to obtain refills on your prescription medications. This is an especially useful benefit for those drugs you take on a regular basis. In many instances, you may pay less for medications obtained using the Caremark mail order service due to greater discounts and lower dispensing fees. Mail service profile forms are available at http://www.khpa.ks.gov

Caremark offers a "FastStart" program. FastStart is designed for first time mail users to help them get started. The member will contact FastStart with their physician and prescription information and FastStart will call their physician and start their mail order. To contact FastStart call 1-866-772- 9503.

The Preferred Drug List will be updated throughout the year. This means drugs will be added and deleted throughout the year. Be sure to check the Preferred Drug List often for changes.

Specialty RX An additional feature of the prescription drug plan is the SpecialtyRx program. This program focuses on members who utilize medications identified as being given by injection, are used by small member populations and are costly. The program offers members a convenient source for these high cost injectables and improved therapy compliance.

Members who elect to participate in the Caremark SpecialtyRx program will have access to pharmacists or nurses 24 hours per day, 7 days a week. These clinicians specialize in the management of chronic conditions. Of course, you may opt-out of the program if you desire.

Mailing Address
Caremark
P.O. Box 52136
Phoenix, Arizona 85072-2136

Customer Service Numbers
Toll free: 800-294-6324
TDD: 800-863-5488

Online Provider Directory and Benefit Description
http://www.khpa.ks.gov

CAREMARK
It all starts with care®

figure 4: Prescription drug tiers

PLAN COVERAGE	TYPE OF PRESCRIPTION MEDICATION	MEMBER PAYS
Tier 1	Generic Drugs	20% coinsurance
Tier 2	Preferred Brand Name Drugs	35% coinsurance
Tier 3	Special Case Medications*	$75 copay per fill
Tier 4	Non Preferred Brand Name Drugs	60% coinsurance
Tier 5	Lifestyle Medications**	100% of discounted price
Coinsurance Max	Tiers 1, 2, & 3 purchases only	$2,580 per member/year

* Very high cost medications used to treat generally life threatening conditions.

** Medications used primarily to enhance lifestyle rather than treat an illness or condition.

Delta Dental Plan

The Delta Dental Plan is a self insured plan administered by Delta Dental of Kansas, Inc. which is responsible for claims processing and customer service, network management and utilization review. All *members* enrolled in medical coverage are also enrolled in the dental plan. You may elect to purchase dental coverage for your *dependents* who are enrolled in the State Health Plan.

Sometimes more than one procedure is available which would restore the tooth to function, according to accepted standards of dental practice. If a more expensive service or benefit is selected over a less costly method, the plan will pay based upon the fee for the least costly method needed to restore function. The remainder of the fee will be the responsibility of the member.

Before getting high cost or major restorative services, members are encouraged to ask their dentist to request a pre-determination before work begins.

Delta Dental will review the course of treatment and advise you and your dentist of the benefits available for the proposed treatment. Benefits paid for accident treatment do not apply toward the annual benefit maximum for other covered services.

Delta Dental Premier Network

The Delta Dental Premier Network is the broad network of providers that members may utilize. Delta Dental will make payment directly to the dental provider. The member will only be responsible for paying the specific coinsurance and deductibles for covered services in addition to any services not covered.

Delta Dental PPO Network

Delta Dental also offers the Delta Dental PPO network. The PPO network providers have agreed to a reduced fee for providing dental services. The PPO network for our group has been expanded to include all PPO providers in the national DeltaUSA PPO network. All members of the Delta Dental program may use the PPO providers whenever desired.

Non Network

Members may use a dental provider who does not contract with Delta Dental. Non network providers may require payment at the time of service. The member will then need to file their own claims and the payment will be mailed to the member. Payment will be subject to applicable deductible and coinsurance and paid based upon the lesser of the actual charge or the customary fee as determined by Delta Dental. Patients are responsible for the entire balance of charges not paid by Delta Dental.

Dental Accidents

Claims for treatment of dental accidents must be processed by the dental plan. Payment for treatment for an accident does not apply to the annual maximum for other services.

Orthodontic Coverage

Procedures for orthodontic appliances and treatment, including both interceptive and corrective, are covered at 50%. Orthodontic treatments are not subject to a deductible and have a $1,000 per person lifetime maximum. The maximum for orthodontic services does not apply to the regular annual maximum for other covered services. To be covered, orthodontic treatment must start after the effective date of dental coverage. For a non network dentist, orthodontic treatment must have started on or after January 1, 2006.

DELTA DENTAL®

Delta Dental of Kansas, Inc.
P.O. Box 789769
Wichita, KS 67278

Customer Service
Toll Free 800-234-3375
In Wichita 316-264-4511

Web site for Provider Directory and Benefit Description
http:/www.khpa.ks.gov

figure 5: Delta Dental chart

PPO	Premier	* Non network	
100%	100%	100%	**Diagnostic and Preventive Services:** >> Oral examinations, prophylaxis/cleanings (including periodontal maintenance) twice per plan year. >> Diagnostic x-rays: bitewings twice per plan year for dependents under age 18 and once per plan year for adults age 18 and over. >> Full mouth x-rays once each five years. >> Topical fluoride twice per plan year for dependent children under age 19. >> Space maintainers only for the premature loss of primary molars and only for dependent children under the age of 15. >> Sealants are covered for dependent children under age 17 and only when applied to permanent molars with no caries (decay) or restorations on the occlusal surface. Sealants are limited to one per four years.
100%	100%	100%	**Ancillary:** Provides for visits to the dentist for the emergency relief of pain.
80%	60%	60%	**Regular Restorative Dentistry:** Provides for amalgam (silver) restorations, composite (white) resin restorations; and stainless steel crowns for dependents under age 12.
			The following procedures are subject to a $45 deductible per person per calendar year not to exceed an annual family deductible of $135:
80%	60%	60%	**Oral Surgery:** Provides for extractions and related oral surgical procedures performed by the dentist including pre- and post-operative care.
80%	60%	60%	**Endodontics:** Includes procedures for root canal treatments and root canal fillings.
80%	60%	60%	**Periodontics:** Includes procedures for the treatment of diseases of the gums and bone supporting the teeth.
50%	50%	50%	**Special Restorative Dentistry:** When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for gold restorations and individual crowns.
50%	50%	50%	**Prosthodontics:** Bridges, partial and complete dentures, including repairs and adjustments.
50%	50%	50%	**TMJ:** Treatment is limited to specific non-surgical procedures involving Temporomandibular Joint Dysfunction. A treatment plan must be preauthorized by Delta Dental.

NOTES: *The maximum paid by the plan for the above treatments is $1,700 per person per calendar year.* The percentage listed is the amount paid by Delta Dental. Benefits are subject to the terms of the benefit description.

* Non network services are subject to the allowed amount including the maximum plan allowance. The plan will determine the amount payable subject to the allowed amount and applicable deductible and coinsurance. Any amounts in excess of the allowed amount will be the member's responsibility.

Superior Vision Services

Superior Vision Services Basic and Enhanced plans are fully insured voluntary vision plans. Employees may elect to enroll themselves and any eligible dependents in one of the vision plans, whether or not the employee or dependents are enrolled in the State's medical coverage. However, if dependent vision coverage is selected and dependent children are also enrolled in the health plan, the dependent children enrolled in vision must match those enrolled in the health plan. Enrollment, even on an after-tax basis, cannot be changed during the Plan Year unless due to either a newly eligible dependent or to a dependent becoming ineligible.

Network Providers
To obtain vision care services under the Basic or Enhanced Plans, the member should contact a Superior Vision network provider. At the appointment, show the ID card or simply indicate enrollment in Superior Vision and provide them the ID number. Superior Vision will pay the network provider for covered services and materials. The member is responsible for any copayments and any additional costs resulting from cosmetic options, or non-covered services and materials selected.

If the member has medical coverage through the State, the health plan will cover one routine eye exam each year. To coordinate benefits with the health plan, the Superior Vision provider will also need the name of the health plan and the member's plan identification number. To maximize benefits, members need to make sure that their chosen provider is a network provider for both the vision and health plans.

Non Network Providers Before a member receives services from a non network provider, they should contact Superior Vision Member Services Department at 1-800-507-3800 to receive an authorization number. After receiving services, the member is responsible for paying the provider in full and submitting itemized receipts along with the authorization to Superior Vision. Reimbursement will be made according to the reimbursement schedule for non network providers listed in the benefit description. It is important to note that the reimbursement schedule does not guarantee full payment.

Superior Vision's Additional Value
Discounts on first pair of fully insured eye wear
Discounts are available for lens add-ons or upgrades not covered by the fully insured benefit. The discount is 20% and is available from providers identified in the provider directory with a "DP".
Discounts on additional eye wear
Discounts are available for additional eye wear purchases. The discounts range from 10% to 30% and are available at providers identified in the provider directory with a "DP".
Discounts on refractive surgeries such as LASIK, RK and PRK
Providers listed in the provider directory with the "RF" designation will provide Superior Vision members with a discount of 20% on refractive surgeries.

Mailing address for claims
Superior Vision Services, Inc.
P.O. Box 967
Rancho Cordova, CA 95741

Customer Service
Toll free 800-507-3800. M - F, 7am to 8pm CST;
Sat, 10am to 3pm CST

Web site address
Provider Directory and Benefit Description
http://www.khpa.ks.gov

Vision Services Chart

figure 6: Vision services chart

BENEFIT TYPE	BASIC PLAN Network	ENHANCED PLAN Network	BOTH PLANS Non network
Subject to $50 copay			
Eye exam, M.D.	Covered in full after copay	Covered in full after copay	Up to $38
Eye exam, O.D.	Covered in full after copay	Covered in full after copay	Up to $38
Subject to $25 materials copay			
Frame	Up to $100 retail*	Up to $100 retail*	Up to $45
Single vision, pair	Covered in full after copay	Covered in full after copay	Up to $31
Bifocal, pair	Covered in full after copay	Covered in full after copay	Up to $51
Trifocal, pair	Covered in full after copay	Covered in full after copay	Up to $64
Lenticular, pair	Covered in full after copay	Covered in full after copay	Up to $80
Progressive lens, pair	Not covered	Covered up to $165*	Not covered
High Index lenses	Not covered	Covered up to $116*	Not covered
Poly-carbonate lenses	Not covered	Covered up to $116*	Not covered
Scratch coat	Not covered	Covered in full	Not covered
UV coat	Not covered	Covered in full	Not covered
Not subject to materials copay			
Contact lenses when medically necessary	Covered in full	Covered in full	Up to $210 Retail
Contact lenses - elective-cosmetic retail	Up to $150 retail*	Up to $150 retail*	Up to $105 Retail

* Members are responsible for any charges above the allowance.

** Members may use only one of the lens allowances per purchase. Members are responsible for any charges above the allowance.

NOTE: Members can use either the contact lens benefit or the eyeglass benefit, but not both in the same Plan Year.

NOTE: Non network claims - copay amount(s) is deducted from the benefit allowance at the time of reimbursement.

NOTE: Covered lenses are standard glass or plastic (CR-39), clear.

KanElect FSA Program

KanElect Flexible Spending Account Program is an Internal Revenue Code, Section 125 plan offered by the State of Kansas. This program allows for the dollars you spend on certain expenses incurred throughout the year to be exempt from taxes. The KanElect program is comprised of three separate benefits.

Pretax Premium Option allows the member to pay for the cost of member sponsored health plan premiums on a pretax basis (elected with health plan enrollment).

Health Care FSA allows the member to use pretax earnings to pay for certain incurred medical expenses allowed by the IRS but not reimbursed by medical, dental, prescription drug or vision insurance. Insurance premiums and other premiums are not reimbursable expenses in an FSA. Members cannot enroll in both a Health Care FSA and a Health Savings Account (HSA) concurrently.

Dependent Care FSA allows the member to use pretax earnings to pay for work-related child care or adult care expenses. (Children must be under the age of 13 for child care expenses.)

Enrollment

Members who want to participate in either the Health Care or Dependent Care FSA in 2007 must enroll during Open Enrollment. Enrollment in an FSA does not roll forward from year to year. Open Enrollment elections for 2007 will become effective on January 1, 2007.

How much should I deposit

It's important that you calculate the right amount to contribute to your FSA account. IRS regulations state that funds remaining in your account after the end of the plan year and grace period will be forfeited. A worksheet is located on the next page to help figure your account(s).

Plan your enrollment based on expenses you expect to incur for services provided while you are covered in the FSA Program. Coverage under either FSA begins on January 1, 2007 or, for new employees, the first of the month following enrollment. Coverage ends on December 31, 2007 or at the end of the month in which contributions ended, whichever is earlier. Claims for eligible Health Care and Dependent Care FSA expenses while covered for 2007 must be filed by April 15, 2008. For plan year 2007, the Health Care FSA, will not offer a grace period for incurring claims after December 31, 2007.

Semi-monthly deduction periods follow:

figure 7: Payroll deduction periods

	Health care FSA	
	Minimum	Maximum
24 semi-monthly payroll deductions	8.00	145.00
16 semi-monthly payroll deductions	12.00	217.50
	Dependent care FSA	
	Minimum	Maximum
24 semi-monthly payroll deductions	16.00	* 208.33
16 semi-monthly payroll deductions	24.00	* 312.50

* Subject to tax filing status.

Additional information is in the Employee Benefits Guidebook which is located online at http://www.khpa.ks.gov

Mailing address
ASI
P.O. Box 6044
Columbia, MO 65205-6044

Toll free fax 866-381-9682

Web site http://www.asiflex.com

Customer service
Infoline: 800-366-4827
ASI customer service 800-659-3035

Representatives available 7am to 7pm weekdays

FSA worksheet

FSA members

Deductibles

Medical, dental, vision $___________

Copayments/Coinsurance

The amount not paid by your plan coverage $___________

Amounts paid over allowed

The amount paid over reasonable and customary allowance $___________

Total A $___________

Expenses NOT covered by insurance plan

Vision care $___________

Dental/orthodontic care $___________

Prescription drugs $___________

* Over-the-counter drugs $___________

Fees/Services $___________

Treatments/therapies $___________

Medical Equipment $___________

Assistance for the disabled $___________

** Other eligible expenses $___________

Total B $___________

Total A & B $___________

FSA dependents

Child care expenses

Day care center $___________

In-home care $___________

Nursery & preschool $___________

After school care $___________

Au pair services $___________

Summer day camps $___________

Elder care services

Day care center $___________

In-home care $___________

Total $___________

Flexible Spending Accounts for members

Use this worksheet to help determine your Health Care Flexible Spending Account election amount. You may want to review receipts from last year for your out of pocket health care expenses. You cannot increase, decrease or cancel your KanElect contribution during the Plan Year unless you experience a status qualifying event; events are listed in the Employee Benefits Guidebook at the web address on the previous page.

Out-Of-Pocket Health Care Expenses: This gives you a good idea of the amount you should elect to place into your Health Care FSA. Consider any other factors that will affect your out-of-pocket health care costs during the upcoming plan year, and adjust the amount if necessary.

Flexible Spending Accounts for dependents

Use this worksheet to help you determine your annual Child Care and Elder Care expenses. Dependent Care FSA allows you to use pre-tax dollars to pay for child care services that make it possible for you and your spouse (if applicable) to work. Under certain circumstances, it also may be used to help pay for the care of elderly parents or a disabled spouse or dependent. Children must be under age 13 for child care expenses.

Note that the Dependent Care FSA is intended to cover costs of child or elder care and does not cover any medical or health care costs for your dependents.

Out-Of-Pocket Dependent Care Expenses: This total gives you an estimated amount that you should elect to place into your Dependent Care FSA. Note: The individual dependent care FSA total shall not exceed $5,000 ($2,500 in case of separate return by a married individual.)

* To treat a medical condition.

** Eligible expenses include any expenses considered deductible by the IRS for federal income tax purposes. See IRS Publication 502 for more information at http://www.asiflex.com.

NOTE: To estimate your tax savings with the KanElect Program, refer to ASI's tax savings calculator at http://www.asiflex.com.

K-SHIP Hearing Program

Kansas State Employees Hearing Improvement Program (K-SHIP) is a program using the Hearing and Speech Departments at five of the Regents Universities. It allows members and their dependents to receive a discount on certain hearing services. Services include hearing evaluations and testing and the hearing testing required to determine the need for hearing aids.

Hearing evaluations may be eligible for coverage under the employee's health plan. To maximize benefits, contact your health plan and ask about coverage. If you are in an HMO, obtain a referral from your primary care physician before obtaining hearing services.

Under K-SHIP, members enrolled in the state health plan and their dependents are eligible to receive a ten percent discount off the cost of covered hearing services. A member does not have to apply for coverage or fill out forms to be eligible for the discount. Simply call one of the clinics, inform them you or your dependent needing service is a state health plan member, and make an appointment. At the time of the appointment, show your prescription drug plan card to verify discount eligibility.

Participating Clinics

Schiefelbusch Clinic
University of Kansas
1200 Sunnyside Ave
2101 Haworth Hall
Lawrence, KS 66045
Voice: 785.864.4690
TTY: 785.864.0667

Hearing and Speech Department
KU Medical Center
3901 Rainbow Boulevard
Kansas City, KS 66160
Voice: 913.588.5730

Speech-Language-Hearing Clinic
Wichita State University
5015 E. 29th
Wichita, KS 67260
Voice: 316.978.3289

Fort Hays State University
Herndon Clinic
Albertson Hall, Room 131
600 Park Street
Hays, KS 67601-4099
Voice: 785.628.5366

Kansas State University
Speech and Hearing Center
139 Campus Creek Complex
Kansas State University
Manhattan, KS 66506-3503
Voice: 785-532-6879

Frequently asked questions

Frequently asked questions

COBRA

1. What is COBRA an acronym for?
Answer: COBRA is an acronym for Consolidated Omnibus Budget Reconciliation Act of 1986.

2. What does COBRA mean to me?
Answer: This federal law requires certain employers to offer continued health insurance coverage when a former member or their qualified dependent loses such coverage for one of the following events:

- a. Termination
- b. Reduction in hours
- c. Death of member
- d. Divorce
- e. Loss of dependent status
- f. Member's entitlement to Medicare

The State and Non-State member plans require the Employer to offer COBRA coverage.

3. How long may I continue on COBRA?
Answer: A member may continue on COBRA for a maximum of 18 months for termination or reduction in hours; all other dependent qualifying events allow for a maximum of 36 months of continuation.

4. What type of coverage is the employer required to offer?
Answer: The employer is required to provide coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated active members or dependents.

5. How much does it cost for COBRA coverage?
Answer: The employee/dependent pays the full cost of COBRA coverage. For more information, go to the following web page http://www.khpa.ks.gov

Dental plan

1. What does Delta Dental cover?
Answer: Two examinations by a contracting dentist which include diagnostic and preventive procedures are covered at 100% of allowable charges; regular restorative dentistry, endodontics, periodontics and oral surgery are covered at 60%; major restorative procedures are covered at 50% when they are provided by a Premier provider. Highest coverage is provided when services are provided by a PPO provider (although there is limited availability). Oral surgery, endodontics, periodontics, special restorative, prosthodontics and TMJ are subject to a deductible.

2. When does the deductible apply?
Answer: The annual deductible applies towards any dental treatment greater than regular restorations (fillings). Preventive visits, emergency pain relief, fillings, and orthodontic work are not subject to the deductible.

3. What happens if I have a dental accident?
Answer: Claims are processed first by the dental plan. Any services not covered by the dental plan may be submitted to your medical plan for

processing provided the services are a covered benefit under the medical plan. If you are in an HMO, your PCP's referral will be required. The medical plan needs to be notified of payments made for dental treatment before it will provide any additional coverage. The amount paid by the dental plan for accident treatment does not apply to the annual maximum for other services.

4. If I end my enrollment in the dental plan, will my dental work continue to be covered?
Answer: Specific procedures started under this plan will be covered after termination of coverage only for those procedures completed within 30 days of termination and submitted for payment within 6 months. The member will need to contact the plan to see which procedures are covered after termination.

5. What is the difference between the Premier network and the PPO Delta Preferred network?
Answer: The Premier network is the largest group of dentists who contract with Delta Dental. Delta Preferred Option (PPO) dentists are a smaller group of providers who take greater discounts and generally cost you less to use.

6. What is the DeltaUSA network?
Answer: This is a national network of Delta Dental PPO and Premier network providers. State of Kansas members are eligible for PPO and Premier coverage anywhere in the United States by using a DeltaUSA provider.

7. What happens if my crown breaks through no fault of my own?
Answer: Individual crowns on the same tooth are covered only once in any five-year period. Only two repairs are allowed in a 12-month period, and recementation is allowed once in a 12 consecutive month period. Discuss options with your dentist if a crown is damaged.

8. Can I find out in advance how much of my dental treatment will be covered?
Answer: Yes. Your dentist can request a predetermination of benefits for you so that you will know approximately what will be covered and what you will be expected to pay.

Group health plans membership and enrollment

1. Which State of Kansas employees are eligible for the health plan?
Answer: Employees are eligible for the health plan if they are working in a position which is not temporary or seasonal and which requires at least 1,000 hours of work per year. Refer to K.A.R. 108-1-1 for additional information.

2. What is the effective date of coverage in the health plan?
Answer: The effective date of coverage is generally the first day of the month following the completion of a 60-day waiting period from date of hire in a benefits eligible position.

3. When can an employee change their health plan coverage during the year?
Answer: Coverage can be changed if the member experiences a qualified status change event and requests the change within 31 days. If approved, the effective date of the change is generally the first day of the month following the date of the qualified event. Please see the current Employee Benefits Guidebook for additional information and restrictions. In an HMO, a health plan change cannot be made simply because your PCP discontinues participation.

4. Who can a member cover on their health insurance?
Answer: A member may cover their spouse

and unmarried children up to age 23 (includes natural or adopted children, stepchildren, or legal custody children). Subject to certain restrictions, the member may also cover grandchildren or handicapped children over age 23. Please see the current Employee Benefits Guidebook online for additional information.

5. If a member terminates employment, when will their health plan coverage end?
Answer: Coverage will end the last day of the month of the member's last day at work. The member will then be offered COBRA continuation coverage.

6. How do I change my Primary Care Physician (PCP)?
Answer: A PCP is required if you are enrolled in an HMO. To change your PCP, telephone your medical plan Customer Service. The telephone number is on your medical insurance card and listed at the front of this booklet.

KanElect

1. What is KanElect?
Answer: KanElect is offered by the State of Kansas for the benefit of its members and is an Internal Revenue Code (IRS) Section 125 plan. It allows the member to pay for unreimbursed health care expenses, and dependent day care expenses with pretax dollars. A member can save an estimated 25-40% in taxes on that portion of their salary that is used for qualifying expenses.

2. If I leave the State of Kansas what happens to my KanElect account?
Answer: Accounts end at the end of the month in which termination occurs. If a member ends their employment with the State or stops making deposits when they have a change in status, they have until April 15th following the end of the plan year to file claims which were incurred up to the end of the month of their termination or status change.

3. If I have funds in my health care account when I leave the State and no eligible expenses, is there any way to claim those funds?
Answer: The period the member was covered on the health care account may be extended on an after tax basis if the member elects continuation of coverage under Flexible Spending Account COBRA. If IRS regulations are met, the member can continue to file dependent care claims for the remaining funds in their account until the end of the plan year.

4. If a member is rehired by the State in the same calendar year can they enroll in the flexible spending accounts?
Answer: No, our plan document only allows one enrollment per calendar year.

5. If a member goes on FMLA leave, what options are available for the KanElect accounts?
Answer: The member has three options:

a. The account(s) may stop at the end of the month in which the member goes on FMLA (if paperwork is completed at that time) and start when they return from leave. If this option is selected there would be no payment for claims incurred during the time the account was inactive.

b. The second option is to continue their contribution to their health care account (no dependent care continuation) by making payments on an after tax basis.

c. The third option on FMLA is to terminate the account for the remainder of the year.

Note: The dependent care account may not be continued while on FMLA because claims are not eligible if a member is not working.

6. Do I have to cover my dependents on the State of Kansas health plan to use their claims on my flexible spending accounts?
Answer: No, they just need to be dependents as defined by the IRS dependent definition.

7. If the date of service for the expense occurs during the current plan year but is not paid for until the following year, can I use that expense on my account during the following year?
Answer: No, all expenses for the current plan year must be incurred between January 1 and December 31 of the current plan year.

8. If I am divorced may I claim dependent care for my child?
Answer: Please refer to IRS Publication 503 under the qualifying person test subheading child of divorced or separated parents. You must first meet the qualification of being the custodial parent.

9. The dependent care maximum is $5,000 (for single or married filing jointly status). Can that expense be for only one child?
Answer: Yes, the maximum is for expenses for one or more children.

10. If both spouses work for the State of Kansas, can they each contribute $5,000 per year to the dependent care account?
Answer: No, per IRS regulation, $5,000 is the maximum per couple filing a joint tax return.

11. If both spouses work for the State of Kansas can they each contribute $3,480 a year to the health care FSA (Flexible Spending Account)?
Answer: Yes.

12. If the member enrolls mid-year in the dependent care account, can they still contribute $5,000?
Answer: No, they are limited to a maximum deduction of $208.33 per semi-monthly paycheck.

13. When will my medical claim reimbursement be paid?
Answer: Medical claims are paid daily, Monday – Friday. See KanElect Claim Forms.

14. What types of health care expenses qualify for the flexible spending account?
Answer: According to IRS regulations, expenses which are eligible for reimbursement are those which would generally be deductible on a federal income tax return (please refer to IRS Publication 502 for further information on qualifying expenses or visit the ASI web site.) An employee may not use this account to pay health insurance premiums for any individual, group coverage, or long term care expenses, even though these expenses are considered tax deductible on their federal income tax return.

15. Does LASIK eye surgery qualify as an eligible health care expense?
Answer: Yes.

16. Can I claim the entire orthodontic fee when I pay it at the time the braces are placed on the teeth?
Answer: No, you may only claim the expense that was incurred for the procedure completed that day. You can claim the amount you paid to have the braces placed on the teeth but not the amount for services to be incurred in the future - monthly fees for maintenance. The IRS will not allow advance reimbursement of future or projected expenses from the Health Care Account. If you wish to pay for the whole year and submit the receipt with a copy of your contract, ASI will take the total divided by 24 paycheck periods and reimburse you for that amount semi-monthly.

17. How long do I have to file my claims?
Answer: For eligible expenses incurred January 1 through December 31, claims may be filed

until April 15. See KanElect Claim Forms. For additional claim forms or copies of Publication 502 and 503, please refer to the ASI web site at www.asiflex.com

18. If I pay my dependent care expenses the first of each month, can I be reimbursed for the whole month the first week?
Answer: No, dependent care services must have been provided (incurred) before you file a claim for the expenses.

Medical plans

1. Why can't I change my health plan option during the middle of the year?
Answer: Certain changes are allowed during the Plan Year for a qualifying event. Generally, the changes follow the Internal Revenue Code 125 guidelines. Please refer to the current Employee Benefits Guidebook

2. Which plans require a Primary Care Physician (PCP)?
Answer: Each of the Health Maintenance Organization (HMO) Plans require the member to select a PCP.

3. If I change my Primary Care Physician, when can I go to my new PCP?
Answer: Members can change their PCP by calling the health plan Customer Service (telephone number on ID card and on inside cover of this booklet). A PCP change is effective the first day of the month following the request for change.

4. If my physician no longer participates in the network, such as Coventry, can I change to Premier Blue during the Plan Year?
Answer: Generally, you will remain in the same health plan for the remainder of the Plan Year even if some of the providers move in and out of the network during the year. However, if you move to a county in which your health plan is not available, you will need to change to another health plan from those which are available for enrollment in that county.

5. What number do I call if I have questions on my health plan?
Answer: The health plan phone numbers are listed on the back of the identification card and on the inside cover of this booklet. In addition, they are also available on our web site at http://www.khpa.ks.gov

6. Do the State health plans have a pre-existing condition waiting period?
Answer: No. The State's health plans do not have a waiting period for coverage of pre-existing medical conditions. Coverage is in effect for all health conditions from the effective date of enrollment.

7. What is the difference between the two PPO plans offered?
Answer: The services covered by the two plans are the same. Both Kansas Choice and Coventry PPO have one level of coinsurance. The major differences lie in the networks, the plan's ability to control cost, which is reflected in the premiums and the customer service provided. For more information, see Health Plan Providers.

8. If the PPO plans have the same benefits, why are premiums different?
Answer: Premiums are based upon the plan experience. Plan experience includes the amount paid for claims and administrative expenses. So it is possible to have two plans with identical benefits to have different claims experience and therefore, different rates.

9. I have had some pain and I went to see my physician. I thought this would be paid under the PPO $450 preventive care service allowance but instead it was applied to my coinsurance. Why?

Answer: The preventive care service allowance is designed to encourage people to see their physician while they are still healthy to assist them in finding potential problems before they become full blown disease states. The services covered under the preventive care allowance are all routine screening services and do not include codes that are filed with claims when people visit their physician's office with a complaint, or illness or any type of diagnosis. To receive the preventive care benefit, you must use a network provider.

10. What happens if my physician sends me to a non network provider for lab, x-rays, anesthesia or other medical treatment?

Answer: Under the HMO plans, it is the primary care physician's responsibility to refer members to contracting providers. If your primary care physician refers you to an out of network provider, the referral must be prior authorized by the Health Plan.

The Kansas Choice PPO plan utilizes the Blue Cross Blue Shield PPO network that contracts with approximately 85% of providers nationwide. When you use a non network provider with Kansas Choice, non network benefits apply.

Coventry PPO has a smaller provider network both locally and nationally and for that reason will make an exception for 'invisible providers'. For example, you have surgery at a network hospital and with a network surgeon, but the anesthesiologist is non network. This 'invisible provider's' claim will be processed at the network level of benefits. However, since there is no contract with this provider, they may bill you any amount above the plan allowance.

11. What happens if there is a medical emergency and I am taken to a non network hospital?

Answer: Under Kansas Choice and Coventry PPO, if your physician refers you to another physician for services, the benefits will be paid based on whether or not that provider is in the plan's networks. If a non network provider is used then non network benefits will be provided. It is up to the member to communicate with their provider(s) in the health plan in which they are enrolled to enable the provider to provide as much assistance as possible. The PPO plans allow members to receive reimbursement from both network and non network providers.

Benefits under Kansas Choice and Coventry PPO are based upon the network status of the provider. If a non network provider is used, non network benefits will be provided. Under an HMO contract, you are covered for initial treatment of a medical emergency. The PCP and the HMO should be contacted as soon as possible regarding treatment options.

12. Will my HMO pay for out of area emergencies?

Answer: You are covered for the initial treatment of a medical emergency but you must contact your PCP and HMO before proceeding with any additional services.

13. For an HMO, must everyone in the family have the same PCP? Where do you find the PCP numbers requested on the application?

Answer: No. Each family member will need to select a PCP. The PCP numbers are available on the web (http://www.khpa.ks.gov) under the provider directory feature of each plan or by calling the HMO.

14. I enrolled in Kansas Choice because my physician was participating in the health plan. Their office has since decided not to continue in the Kansas Choice network. Can I make a mid-year election to switch to another health plan that my physician does participate in?
Answer: No. Changes in the provider network can occur at anytime on any of the health plans. Since the provider contracts are between the health plan and the provider, the State can not guarantee access to specific providers. Under Kansas Choice and Coventry PPO you can continue to see the provider under the out of network benefit or choose another provider who does participate in the network. Members with an HMO need to select another provider if their PCP leaves the network. Remember, you will have the opportunity during open enrollment in October of each year to switch health plans for the next year should you desire.

15. Do the copays for office visits, emergency room, outpatient mental health visits, and hospital stays apply toward my deductible or coinsurance.
Answer: No. Copays are not credited toward deductibles or coinsurance. Copays occur each time service is obtained.

16. If I go to a non network provider, what will I pay toward the non network deductibles and coinsurance to satisfy my network deductibles and coinsurance?
Answer: Under the PPO plans, network and non network services accumulate separately. The non network deductible is $500 for single and $1,500 for family per plan year.
Coinsurance amounts accumulate separately for network and non network services. The coinsurance for non network is 50%.

17. What is the coinsurance maximum and how is it calculated?
Answer: Coinsurance is the sharing of expenses between the health plan and the member. Kansas Choice and Coventry PPO programs have separate coinsurance provisions for claims received from network and non network providers. As claims are processed by the health plan, the member's share of coinsurance is accumulated based on the network status of the provider. Once a member's share reaches the coinsurance maximum stated in the policy, any additional claims from providers with the same network status are processed and paid at 100 percent of the allowed amount for the remainder of the plan year. For a family, two or more member's coinsurance is pooled to reach the coinsurance maximum for the family. Again, this is tracked separately for network and non network providers.

18. Does the money I spend out of pocket for the deductible count toward the coinsurance maximum? Do the copays count toward the maximum?
Answer: No. The deductible is the amount of covered services you must pay out of pocket before the health plan begins to pay benefits. This amount does not count toward the coinsurance maximum. Copays are a flat dollar cost sharing amount for certain services like office visits. Amounts paid for copays do not count toward the coinsurance maximum.

19. Is chiropractic coverage included in the health plans?
Answer: Chiropractic care is considered a physical rehabilitation benefit and is covered, subject to medical necessity for up to 30 visits per year. The health plans will request medical records from the chiropractor, just as they would from a physician or physical therapist. Medical records must show continued improvement in condition. HMO members will need a referral from their PCP.

Prescription drug plan

1. What is a Preferred Drug List?
Answer: A Preferred Drug List identifies those prescription drug products that are preferred by the plan for dispensing to members when appropriate. This list is subject to periodic review and modification.

2. How is the State of Kansas Prescription Drug Preferred Drug List determined?
Answer: The State of Kansas group Health Plan uses the Caremark National Formulary list with the following limited exceptions - all forms of insulin and covered diabetic supplies will be paid by the member at 20% coinsurance level if generic, and 35% coinsurance level for preferred brand name drugs (whether or not they are on the Caremark national formulary).

3. What are Special Case Medications?
Answer: Special Case Medications are high costing medications used for treatment of catastrophic conditions. A list of special case medications is on the web site and is subject to review. There is a $75 copay per standard fill for 2007.

4. Does the prescription drug plan cover diabetic supplies?
Answer: Yes. The prescription drug plan does cover diabetic supplies that are medically necessary and prescribed by a physician. Diabetic testing equipment (glucometers, etc) are covered under the health plans.

5. How can I save money on my prescription drugs?
Answer: When your physician gives you a prescription, ask if a generic is available and if it would be appropriate for you. If the physician says you must take a brand name drug, ask if there is a drug listed on the Preferred Drug List that you can take. You can find the Preferred Drug List on Caremark's web site or by calling them at 1-800-294.6324. Print off a copy to share with your physician at each office visit.

6. How do I use the prescription drug mail order program?
Answer: To participate in the mail order program, you will need to complete the Mail Service Profile form available on the Caremark web site. Submit this form along with an original prescription from your physician to Caremark. Please allow 2 weeks for processing. The initial fill will be 30 days. For faster refills order from the Caremark web site or call 1-800-294-6324.

7. What are lifestyle prescription medications?
Answer: Lifestyle medications are primarily used for weight loss, smoking cessation, infertility, erectile dysfunction, medications for cosmetic purposes, dental preparations (toothpaste, mouthwash, etc.) and Drug Efficacy Study Implementation (DESI-5) medications. DESI-5 medications are older medications that require a prescription but which the Food and Drug Administration (FDA) have approved for safety only and not safety and effectiveness. Also included in this category are Reserve RX medications (medications whose active ingredient does not require a prescription but whose manufacturer has decided to sell only with a prescription) and ostomy supplies.

8. Since the prescription drug plan does not pay for lifestyle medications, why is this a benefit?
Answer: The benefit to members is that they

receive the same discount the State has negotiated for the prescription drug plan on these items. So the member pays the negotiated discount plus a dispensing fee instead of the retail price of the product.

9. What are special case drugs?
Answer: They are high cost medications used for treatment of catastrophic conditions. A list of special case medications is on the web site at http://www.khpa.ks.gov and is subject to review. There is a $75 copay per fill for 2007.

10. My physician has prescribed Glucagon, a medication that I will inject myself with each day. Is that covered under the health or prescription drug plan?
Answer: This self-injectible medication is covered under the Caremark prescription drug plan. A complete list of all self-injectible medications is available at the following web site: http://www.khpa.ks.gov.

11. I have tried several of the Preferred Drug List medications and they have not been effective in treating my conditions. I have used a non preferred medication in the past that was effective. Is there anyway to add this to the Preferred Drug List?
Answer: No. The state plan utilizes Caremark's Preferred Drug List (PDL). Members are not able to request that Caremark change the PDL. However, the PDL override process addresses this situation since it allows the non preferred medication to be processed at the preferred brand medication coinsurance rate.

Prescription overrides are available in the following instances.

a. The member has tried two preferred medications and medical evidence indicates the preferred mediations were ineffective.

b. The member could not tolerate the preferred medication.

c. There is not a generic or brand name preferred medication available or other plan criteria are met.

The prescribing physician must request the prescription override on the member's behalf by calling Caremark at 1-800-294-5979. Please note: this telephone number is for use by physicians and their staff only. It is not a customer service line for members. Initial information will be taken by telephone. A form will be faxed to the physician for signature. Approvals may be granted if the member meets the plan criteria stated above. The coinsurance paid on drugs with prescription overrides does not apply toward the coinsurance maximum.

12. Explain how the prescription drug coinsurance/copay maximum works.
Answer: For 2007, the coinsurance for generic and preferred brand drugs and the copay for special case medications are capped at a set dollar amount. For 2007, the max is $2,580 per person per plan year. Once the member's share of eligible drugs reaches the coinsurance/copayment maximum, any additional generic, preferred or special case drugs will be covered by the plan at 100 percent for the remainder of the plan year. There is no cap on the coinsurance for non preferred drugs or those with a prescription override.

Vision plan

1. I am enrolled in the vision plan and I didn't get an ID card for the vision plan; should I?
Answer: If you enrolled, the ID card was included on the bottom of the cover letter sent with your enrollment packet. The ID card is not required to access care. Advise your provider of

your Superior Vision coverage and they can call to verify coverage.

2. Who can be covered in the vision plan?
Answer: Members may elect any coverage on either the Basic or Enhanced vision plan regardless of enrollment in a health plan. Coverage levels include: member only; member and spouse only; member and child(ren) only; member and family (spouse and children); or waive.

3. Why is the deductible for a routine eye exam so high on the vision insurance?
Answer: The deductible is set at $50 for the vision insurance because all of the health plans include coverage for a routine eye exam as part of the medical coverage. If you are covered under vision, be sure to advise your physician's office of both insurance plans when seeking treatment.

4. What is the difference between the Basic Vision Plan and the Enhanced Vision Plan?
Answer: The Enhanced plan covers everything the Basic plan does plus basic progressive (no-line bifocals), high index lenses, polycarbonate lenses, scratch coating and ultraviolet protective coating.

5. What are progressive power lenses?
Answer: Progressive power lenses are an alternative to the typical bifocal and trifocal lens designs that have small "windows" in the lower half of the lens. The progressive power lens has the power for distance vision at the top of the lens, like bifocal and trifocal lenses, however, the power of the lens then becomes progressively stronger from the mid-point of the lens to the bottom of the lens. Hence, the lens design is described as "progressive power". This lens design is also referred to as a "no line" lens. The power change enables the wearer to focus clearly at distance, at mid-point (arm's length) and all the way through to the near-point (reading area). There are definite advantages to wearing progressive power lenses as opposed to standard bifocal and trifocal lenses. However, because there is some visual distortion at the periphery of the progressive power lens, some people have difficulty adjusting to them.

6. What kinds of progressive power lenses are there?
Answer: Progressive power lenses are available from a number of different manufacturers with many variations in design and curvature configuration. The lenses are also made in different materials, such as glass, plastic, transitions, High Index, Polaroid, etc. As a result, lens prices can vary greatly depending on these variations.

7. I went to the eye physician at my local WalMart for an exam but they are not in the network. I thought all of the WalMart stores were in Superior's network?
Answer: All WalMart Vision Centers are contracted into the Superior Vision Plan Network. The associated optometrists, who are not employees of WalMart must be contracted individually. Superior Vision has contacted all WalMart associated optometrists in Kansas and will continue to promote the participation of those not yet in the network. Superior Vision cannot, however, guarantee that all of the optometrists will contract.

8. My physician wrote me a prescription for contact lenses. Does that mean they are considered medically necessary by the plan?
Answer: No. Medically necessary contacts are contact lenses required due to a medical condition such as cataracts or glaucoma for which glasses are not an alternative treatment.

Glossary

Glossary

Allowable charge The maximum amount a health plan will pay for a covered service. Network providers and facilities are those who have agreed to accept the allowable charge for covered services under the plan.

Billed Charges The difference between the allowed amount and actual charge. A network provider will write off this amount. A non network provider will usually not write off this amount and it will become the members responsibility to pay.

Buy-up The state contribution to member health care premiums is based on the lowest cost HMO or PPO available in the member's residential county. In any county, if the plan selected by the member is not the lowest cost option, the member will pay the difference - that is called the 'buy-up' - to the plan of their choice.

Coinsurance The percentage of covered medical expenses a member must pay in conjunction with the percentage paid by an insurance plan for covered expenses. These amounts are called coinsurance because both the member and the insurance plan share the cost of health care expenses.

Coinsurance maximum A set dollar amount identified in the contract of insurance. Once the amount you pay out of your pocket as coinsurance reaches this amount, covered services are paid at 100% of the allowed charge with no further coinsurance applied for the remainder of the plan year. You may be responsible for amounts that exceed the allowed charge if you are receiving services from a non network provider. Copayments do not apply to coinsurance maximums.

Coordination of benefits A system to eliminate duplication of benefits when a person is covered under more than one group health plan. Benefits under the two plans are limited to no more than 100 percent of the claim.

Copayment A copayment is a fixed dollar amount of covered medical expenses a member must pay in addition to what is paid by an insurance plan for covered expenses. These amounts are called copayments because both the member and the insurance plan share the cost of health care expenses.

Covered medical expense The allowable charge for a medical procedure that is covered by the contract of insurance and is deemed medically necessary by the health plan in the diagnosis or treatment of an illness or injury.

Deductible A set dollar amount you must pay out of your pocket each year from covered medical services before the insurance plan begins to pay claims. The deductible is shown on the schedule of Benefits of the policy.

Dependent A lawful wife or husband or an unmarried child or stepchild of a members family who meets the eligibility requirements and who is properly enrolled for coverage by the member and on whose behalf premiums are paid by You or the Employer Group.

Employee Advisory Committee A committee consisting of active state employees and state retirees who advise the Kansas Health Care Commission on health care coverage.

Employee Benefit Guidebook A listing of policies concerning State of Kansas employee benefits.

Employee Self Service Center The web site for members to join, verify, or make changes to their health plan.

Exclusion A specific condition or circumstance for which an insurance plan or policy will not provide benefits.

Explanation of Benefits (EOB) A statement sent to a member by the health plan that indicates the name of the provider, total amount billed, amount paid by the plan, and amount the member is responsible for paying to the provider. This is not a bill and should be retained to show how the claim was processed.

Fully insured Under a fully insured plan, the employer purchases coverage from an insurance company. The insurance company assumes the risk to pay claims for covered services based on contracted allowances.

Health Maintenance Organization (HMO) A managed care plan that has contractual arrangements with health care providers (physicians, hospitals, etc.) who together form a provider network. HMO members are required to see only providers within this network. If a member receives care outside of this network, the HMO will not pay benefits for these services *unless* the care was pre-authorized or deemed an emergency. Members choose a primary care physician (PCP) who coordinates all aspects of the member's health care. To receive benefits, members must receive a referral from their PCP before they can see a specialist.

Health Savings Account (HSA) The Health Savings Account, or HSA, was created by federal legislation that lets you set aside pre-tax dollars for future medical, retirement, or long-term care premium expenses. The funds can roll over from year to year. You take them with you when you change jobs. To open an HSA, you must be enrolled in a Qualified High Deductible Health Plan (see definition).

HealthyKIDS A program that helps eligible members with their premiums for children's health insurance coverage. Eligible families have up to 90 percent of their premiums for children covered by the state.

KanElect The Flexible Spending Account available to members that allows for certain expenses to be exempt from taxes. Qualifying expenses in KanElect include certain medical expenses not covered by medical, prescription drug, dental or vision plans, and dependent care costs.

K-Ship K-SHIP is a hearing improvement program using the hearing and speech departments at each of the five Regents Universities. It allows members who are enrolled in the State of Kansas Group Health Insurance Program and their covered dependents to receive a discount on certain hearing services.

Medically necessary Services or supplies ordered by a physician or provider to identify or treat an illness or injury. Services and supplies must be given in accordance with proper medical practice prevailing in the medical specialty or field at the time the member receives the service and in the least costly setting required for the member's condition. The service must be consistent with the member's illness, injury or condition and be required for reasons other than the member's convenience. The fact that a physician prescribes a service or supply does not necessarily mean it is medically necessary.

Network provider (*or contracting provider*) An eligible provider who has entered into a contracting agreement directly with a health insurance company to provide services to members for specific pre-negotiated rates.

Non network provider (*or non contracting provider*) An eligible provider who has not entered into a contracting agreement with the insurance company. If you visit a physician or other provider within the network, the amount you will be responsible for paying will be less than if you go to a non network provider. In many cases, the insurance company will either pay less or not pay anything for services you received from non network providers.

Open enrollment	The time period between October 1 and October 31, 2006, when members have the opportunity to join, verify, or make changes to their health plan.
Pre-admission certification	A plan requirement that you call the health plan prior to admission to the hospital for non-emergency care. Pre-certification is not a guarantee that benefits will be paid.
Preferred Provider Organization (PPO)	A PPO has arrangements with physicians, hospitals and other providers who have agreed to accept the health plan's allowable charge for covered medical services as payment in full and will not balance bill you. Participating providers also file claims for you. You can see anyone in the network of providers.
Primary Care Physician (PCP)	A physician selected by the member of an HMO plan from the list of physicians engaged in general practice, family practice, internal medicine or pediatrics who is participating in the selected HMO plan to be the physician who will manage and/or coordinate the member's health care needs.
Qualified High Deductible Health Plan (QHDHP)	A Qualified High Deductible Health Plan is defined in the federal legislation creating HSAs. The QHDHP offered to members has an annual individual deductible of $1,500 and family coverage with a minimum deductible of $3,000. In addition to the deductible amounts, the QHDHP has maximum combined out of pocket expenses of coinsurance and deductibles of $5,000 for individual and $10,000 family maximums for in-network expenses. Minimum amounts are indexed annually by IRS.
Qualifying event	An event that allows changes to insurance coverage or an extension of insurance coverage for a member, spouse or dependent. Such events may be marriage, birth/adoption/ placement, loss of group health plan coverage, divorce/legal separation, death of the covered member, loss of dependent(s) eligibility for coverage, etc. When a qualifying event occurs you have 31 days to contact your human resource office and complete the forms in order to make the change to your membership.
Self insured	Self insured plans are set up by employers to pay the health claims of its employees. The employer assumes the risk of providing the benefits and is obligated to pay claims for covered services based on contracted allowances.

State Employee Service Center web site

http://www.kansas.gov/employee

Other Helpful Web Sites

Employee Benefits Guidebook A complete listing of the policies regarding the State of Kansas employee benefits. The Guidebook is located on the Health Policy Authority web site http://www.khpa.ks.gov

Agency for Health Care Research and Quality This site includes a pocket guide to good health for adults. It provides information on health conditions/diseases/prescriptions/prevention & wellness http://www.ahrq.gov

Staying in Healthy Shape How to stay healthy. Here you'll find information on diseases/conditions/interactive tools/calculators/ health quizzes, etc. This site is offered in English and Spanish http://www.stayinginshape.com

Collaborative Care Includes links to more than 20 good health resources. This site helps patients become informed about their medical options, communicate effectively with their physicians, and achieve better overall health outcomes http://www.collaborativecare.net

American Medical Association Includes general legislative information and publications on public health http://www.ama-assn.org

National Institutes of Health A source for general background information on health conditions and research. Here you will find "Talking with your physician – A guide for older people" which is good information for anyone http://www.nih.gov

Centers for Disease Control This site includes health and safety topics/publications and products/data and statistics http://www.cdc.gov

National Patient Safety Foundation A resource that provides a library of information on patient safety http://www.npsf.org

Kansas Department of Insurance This site includes useful information on how to "Take Control" of your health care http://www.ksinsurance.org

U.S. Department of the Treasury Provides detailed information about health savings accounts http://www.treas.gov/offices/public-affairs/hsa/

Healthy People A place to embrace habits of lean, healthy, energetic people! http://www.healthypeople.com

Choosing your Health Care Plan with the State of Kansas

A summary of the state health plans available to active state employees

2006 Open Enrollment for Plan Year 2007

Published by the Kansas Health Policy Authority

Design: Lawson Phillips Associates, LP, AM, TH

Printed and bound by the Division of Printing, Kansas Department of Administration

Text set in Warnock, designed for Adobe Systems by Robert Slimbach, 2000

Figures set in Myriad, designed by Carol Twombly, Robert Slimbach, and the design staff at Adobe Systems, 1992

Titles set in Myriad and Verdana, the latter designed for Microsoft by Matthew Carter, 1996

Gusto text (70lb) and cover (80lb) papers are by Storaenso: they are acid free, all pulp being elemental chlorine free (ECF) or totally chlorine free (TCF)

Topeka 2006

NOTE: The information in this booklet is intended to summarize the benefits offered in language that is clear and easy to understand. Every effort has been made to ensure that this information is accurate. It is not intended to replace the legal plan document (Certificate of Coverage or Benefit Description) which contains the complete provisions of a program. In case of any discrepancy between this booklet and the legal plan document, the legal plan document will govern in all cases. You may review the legal plan document upon request or view them at our web site: http://www.khpa.ks.gov. The Health Care Commission reserves the right to suspend, revoke or modify the benefit programs offered to employees. Nothing in this booklet shall be construed as a contract of employment between the State of Kansas and any employee, nor as a guarantee of any employee to be continued in the employment of the State, nor as a limitation on the right of the State to discharge any of its employees with or without cause.

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